

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER CELINA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 272
SS=D

**483.20(b)(1) COMPREHENSIVE
ASSESSMENTS**

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

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This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

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1. Resident # 18 was scheduled a dental consult by the Social Services Director on 12/1/11. Resident # 18 was assessed for pain by the Director of Nursing on 12/1/11 which the resident denied. The MD and family were notified on 12/1/11 by the Director of Nursing.
2. All resident dental assessments were reviewed on 12/1/11 by the Director of Nursing and the Social Services Director. No other

Completion
Date
12/22/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul Borne</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/14/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to comprehensively assess the dental needs for one resident (#18) of thirty-one residents reviewed. The findings included: Resident #18 was admitted to the facility on September 27, 2011, with diagnoses including Severe Anemia, Acute Renal Failure, Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated October 4, 2011, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status indicating the resident was moderately cognitively impaired. Continued review of the same MDS, Section L, Oral/Dental Status revealed, "No natural teeth or tooth fragments." (edentulous) Review of the Nursing Admission Assessment dated September 27, 2011, Dental Status section revealed, "0" number of natural upper teeth; "0" number of natural lower teeth. Continued review revealed "does not have any dentures...Resident capable of accepting and cooperating with dental work? Yes..." Medical record review of the Dietary/Interview/Prescreen assessment dated September 28, 2011, revealed the resident was edentulous, and had chewing problems.	F 272	residents were identified as having been affected. 3. The Interdisciplinary Team consisting of the MDS Coordinator, Social Services Director, Licensed Nursing Staff, Activities Director, and Dietary Manager were inserviced by the Administrator beginning 12/1/11 through 12/13/11 regarding proper assessment, care planning, and provision of dental services. 4. The Director of Nursing will audit fifteen dental assessment per week for four weeks then fifteen charts per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing		

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F 272 Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to comprehensively assess the dental needs for one resident (#18) of thirty-one residents reviewed.

The findings included:

Resident #18 was admitted to the facility on September 27, 2011, with diagnoses including Severe Anemia, Acute Renal Failure, Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and Alzheimer's Dementia.

Review of the Minimum Data Set (MDS) dated October 4, 2011, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status indicating the resident was moderately cognitively impaired. Continued review of the same MDS, Section L, Oral/Dental Status revealed, "No natural teeth or tooth fragments." (edentulous)

Review of the Nursing Admission Assessment dated September 27, 2011, Dental Status section revealed, "0" number of natural upper teeth; "0" number of natural lower teeth. Continued review revealed "does not have any dentures...Resident capable of accepting and cooperating with dental work? Yes..."

Medical record review of the Dietary/Interview/Prescreen assessment dated September 28, 2011, revealed the resident was edentulous, and had chewing problems.

F 272

Coordinator, Minimum Data Set
Coordinator, Social Services,
Activities Director, Dietary
Manager, and Housekeeping
Supervisor.

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F 272	Continued From page 2 Review of the Resident Interview information dated November 28, 2011, at 11:49 a.m., revealed the resident confirmed, "...sometime gums hurt throughout the day..." Observation on December 1, 2011, at 1:30 p.m., revealed the resident eating a meal consisting of mechanical soft, pureed meat food items. Interview with the Director of Nursing (DON) in the DON's office on December 1, 2011, at 2:30 p.m., confirmed after contacting the resident's responsible party, the resident's dentures had been lost at the hospital, the resident was unable to wear an old set of dentures because they didn't fit properly, and the family would like the resident to be refitted for new dentures. Continued interview confirmed the facility had not completed the dental assessment to determine the resident's need for dentures.	F 272			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to follow physician orders for the treatment of Constipation for one resident (#50) of thirty-one residents reviewed. The findings included: Resident #50 was admitted to the facility on	F 281	F281 1. The Charge Nurse received clarification orders for Resident # 50 regarding the bowel protocol on 11/30/11. The Charge Nurse implemented the bowel protocol for this resident on 11/30/11. The MD and family were notified on 11/30/11 by the Director of Nursing. 2. All residents in the facility were audited by the Director of Nursing and the Staffing Coordinator to insure that the bowel protocol was being implemented on 11/30/11. No other residents were identified as having been affected.	Completion Date 12/22/11	

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F 281	<p>Continued From page 3</p> <p>February 12, 2009, with diagnoses including Uncontrolled Diabetes, Hypertension, Esophageal Reflux, Cerebral Vascular Accident, Intracranial Hemorrhage, and Neuropathy. Review of the Minimum Data Set dated September 7, 2011, revealed the resident to be severely cognitively impaired, with a score of six (out of a possible total of fifteen), on the Brief Interview for Mental Status.</p> <p>Medical record review revealed "Physician's Standing Orders" for resident #50 contained the following prescribed regime for constipation: "...No BM (Bowel Movement) X (times) 1 day = 4 oz (ounces) prune juice; No BM X 2 days = MOM (Milk of Magnesia, a laxative) 30 cc po (one ounce by mouth); No BM X 3 days = Call MD for further orders..."</p> <p>Medical record review of the facility "BM with detail" document for November 2011, revealed no documentation the resident had a BM on November 10th, 11th, and 12th, 2011, and the BM protocol had not been implemented. Continued review revealed no documentation the resident had a BM on November 14th and 15th, 2011, and the BM protocol had not been implemented. Continued review revealed no documentation the resident had a BM on November 24th, 25th, and 26th, 2011. Continued review revealed the resident received prune juice on November 25, 2011, but nothing on the November 26, 2011. Continued review revealed no documentation the resident had a BM on November 28th and 29th, 2011, and the BM protocol had not been implemented.</p> <p>Interview with the Director of Nursing (DON) in</p>	F 281	<p>3. All licensed nurses were inserviced on 11/30/11 regarding the bowel protocol by the Director of Nursing.</p> <p>4. The Director of Nursing will audit fifteen charts per week for four weeks then fifteen charts per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.</p>		

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F 281	Continued From page 4 the DON's office, on December 1, 2011, at 7:50 a.m., confirmed the bowel protocol for managing constipation in the Physician's Standing Orders had not been followed.	F 281	F282 1. Resident # 18 was scheduled a dental consult by the Social Services Director on 12/1/11. Resident # 18 was assessed for pain by the Director of Nursing on 12/1/11 which the resident denied. The MD and family were notified on 12/1/11 by the Director of Nursing. Resident #18's care plan was updated by the Director of Nursing to reflect current plan of care. 2. All resident care plans were reviewed on 12/1/11 by the Director of Nursing and the Social Services Director to insure they accurately reflected plan of care for dental needs. No other residents were identified as having been affected. 3. The Interdisciplinary Team consisting of the MDS		Completion Date 12/22/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the care plan for one resident (#18) of thirty-one residents reviewed. The findings included: Resident #18 was admitted to the facility on September 27, 2011, with diagnoses including Severe Anemia, Acute Renal Failure, Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated October 4, 2011, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status indicating the resident was moderately cognitively impaired. Continued review of the same MDS, Section L, Oral/Dental Status revealed, "No natural teeth or tooth fragments." (edentulous) Review of the resident's Care Plan dated September 27, 2011, revealed, Problem	F 282			

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F 282	Continued From page 5 Identification "Resident has impaired oral health, edentulous..." Continued review revealed, "...Goal "resident will have no oral discomfort by 90 day assessment..." Review of approaches to address dental problems revealed, "...dental consult as needed..." Medical record review of the Dietary/Interview/Prescreen assessment dated September 28, 2011, revealed the resident was edentulous, and had chewing problems. Review of the Resident Interview information dated November 28, 2011, at 11:49 a.m., revealed the resident confirmed, "...sometime gums hurt throughout the day..." Interview with the Director of Nursing in the Director's office on December 1, 2011, at 2:30 p.m., confirmed the facility had not made arrangements for a dental consult.	F 282	Coordinator, Social Services Director, Licensed Nursing Staff, Activities Director, and Dietary Manager were inserviced by the administrator beginning 12/1/11 through 12/13/11 regarding proper assessment, care planning, and provision of dental services.		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.	F 411	4. The Director of Nursing will audit fifteen dental assessments per week for four weeks then fifteen charts per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.		

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F 411	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a dental consult for one resident (#18) of thirty-one residents reviewed. The findings included: Resident #18 was admitted to the facility on September 27, 2011, with diagnoses including Severe Anemia, Acute Renal Failure, Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated October 4, 2011, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status indicating the resident was moderately cognitively impaired. Continued review of the same MDS, Section L, Oral/Dental Status revealed, "No natural teeth or tooth fragments." (edentulous) Review of the Nursing Admission Assessment documentation dated September 27, 2011, Dental Status, revealed, "0" number of natural upper teeth; "0" number of natural lower teeth. Continued review revealed "does not have any dentures"...and "Resident capable of accepting and cooperating with dental work? Yes..." Medical record review of the Dietary/Interview/Prescreen assessment dated September 28, 2011, revealed the resident was edentulous, and had chewing problems.	F 411	F411 1. Resident # 18 was scheduled a dental consult by the Social Services Director on 12/1/11. Resident # 18 was assessed for pain by the Director of Nursing on 12/1/11 which the resident denied. The MD and family were notified on 12/1/11 by the Director of Nursing. 2. All resident dental assessments were reviewed on 12/1/11 by the Director of Nursing and the Social Services Director. No other residents were identified as having been affected. 3. The Interdisciplinary Team consisting of the MDS Coordinator, Social Services Director, Licensed Nursing Staff, Activities Director, and Dietary Manager were inserviced by the administrator beginning	Completion Date 12/22/11	

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F 411	Continued From page 7 Interview with the resident on November 28, 2011, at 11:49 a.m., confirmed, "...sometimes gums hurt throughout the day..." Observation on December 1, 2011, at 1:30 p.m., revealed the resident eating a meal consisting of mechanical soft, pureed meat food items. Interview with the Director of Nursing (DON) in the DON's office on December 1, 2011, at 2:30 p.m., confirmed the resident's family had been notified and provided the following information, the resident's dentures had been lost at the hospital prior to admission to the nursing facility, the resident was unable to wear an old set of dentures because they didn't fit properly, and the family would like the resident to be refitted for new dentures. Continued interview confirmed the facility had not made arrangements for the resident to receive dental services.	F 411	12/1/11 through 12/13/11 regarding proper assessment, care planning, and provision of dental services.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	4. The Director of Nursing will audit fifteen dental assessments per week for four weeks then fifteen charts per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.		

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F 441	Continued From page 8 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation, and interview, the facility failed to ensure medication was administered in a sanitary manner for one (#29) of twelve residents reviewed during the medication administration review. The findings included: Observation on November 29, 2011, at 11:26 a.m., revealed Licensed Practical Nurse (LPN #1) was preparing to administer medications to resident #29. Continued observation revealed the LPN crushed the medications Carafate (to	F 441	F441 1. LPN #1 was inserviced on 11/29/11 regarding medication administration policies. Resident # 29 was assessed by the Director of Nursing on 12/1/11 for any adverse affects. No adverse outcomes were identified. The MD and family were notified on 12/1/11 by the Director of Nursing. 2. The Director of Nursing began medication pass observations on 11/29/11 to ensure that medication administration policies were being followed consistently for all residents. No other residents were identified as having been affected. 3. All licensed nurses were inserviced on 12/2/11 by the Director of Nursing regarding following infection control practices in medication administration.		Completion Date 12/22/11

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NAME OF PROVIDER OR SUPPLIER CELINA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PITCOCK LANE CELINA, TN 38551	
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F 441	<p>Continued From page 9</p> <p>treat/prevent ulcers) and Seroquel (to treat Schizophrenia) and mixed in applesauce. Continued observation revealed the LPN removed a group of 4 Potassium Chloride 10 meq (millequivalents) capsules. Continued observation revealed LPN #1 pulled back the manufacturers' label from the plastic package and with the bare fingers removed two capsules and placed them in the applesauce mixture.</p> <p>Review of the facility documentation titled Medication Pass Evaluation (serves as facility guideline) revised September 28, 2011, revealed, "Meds (medications) touched by nurse, dropped on cart or floor are disposed of and hand hygiene is performed..."</p> <p>Interview with the Director of Nursing (DON) on December 1, 2011, at 3:25 p.m., in the DON's office confirmed the facility failed to ensure the medication was administered in a sanitary manner.</p>	F 441	<p>4. The Director of Nursing will conduct five medication administration observations per week for one month then five observations per month for two months to monitor compliance or until 100% compliance is achieved. All results will be reported monthly to the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.</p>	